		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042366

Facility Name: MAPLE RIDGE CARE CENTRE

Address: 2202 N. KICKAPOO (Number) LINCOLN (City) 62656 (Zip Code)

County: LOGAN

Telephone Number: (217) 735-1538 **Fax #** (217) 735-4818

IDPA ID Number: 36-4109662

Date of Initial License for Current Owners: 11/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,125	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,880	889	5,344	10,113	8
9	SNF/PED					9
10	ICF	23,838	5,613	1,486	30,937	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,718	6,502	6,830	41,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.72%

D. How many bed-hold days during this year were paid by Public Aid?
262 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,979

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	149,523	22,377	10,637	182,537		182,537	(3,316)	179,221			1
2	Food Purchase		156,212		156,212		156,212	(1,086)	155,126			2
3	Housekeeping	145,970	16,409		162,379		162,379	(4,282)	158,097			3
4	Laundry	23,904	9,679	94	33,677		33,677		33,677			4
5	Heat and Other Utilities			132,557	132,557		132,557		132,557			5
6	Maintenance	43,135	19,334	33,983	96,452		96,452	(7,331)	89,121			6
7	Other (specify):*			13,430	13,430		13,430		13,430			7
8	TOTAL General Services	362,532	224,011	190,701	777,244		777,244	(16,015)	761,229			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,258,488	74,609	5,917	1,339,014		1,339,014	(11,071)	1,327,943			10
10a	Therapy			5,806	5,806		5,806		5,806			10a
11	Activities	94,405	7,623	2,732	104,760		104,760	(792)	103,968			11
12	Social Services			2,732	2,732		2,732		2,732			12
13	Nurse Aide Training			2,757	2,757		2,757		2,757			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,352,893	82,232	37,944	1,473,069		1,473,069	(11,863)	1,461,206			16
	C. General Administration											
17	Administrative	59,878		386,995	446,873		446,873	(374,934)	71,939			17
18	Directors Fees											18
19	Professional Services			141,693	141,693		141,693	41,190	182,883			19
20	Dues, Fees, Subscriptions & Promotions			71,028	71,028		71,028	(57,462)	13,566			20
21	Clerical & General Office Expenses	90,234	23,222	90,178	203,634		203,634	94,993	298,627			21
22	Employee Benefits & Payroll Taxes			381,419	381,419		381,419		381,419			22
23	Inservice Training & Education			11,582	11,582		11,582		11,582			23
24	Travel and Seminar			886	886		886	6,295	7,181			24
25	Other Admin. Staff Transportation			6,163	6,163		6,163		6,163			25
26	Insurance-Prop.Liab.Malpractice			93,569	93,569		93,569	24,118	117,687			26
27	Other (specify):*			114,085	114,085		114,085	(114,085)				27
28	TOTAL General Administration	150,112	23,222	1,297,598	1,470,932		1,470,932	(379,885)	1,091,047			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,865,537	329,465	1,526,243	3,721,245		3,721,245	(407,763)	3,313,482			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE #0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,235	34,235		34,235	157,539	191,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			161,501	161,501		161,501	129,028	290,529			32
33	Real Estate Taxes			30,486	30,486		30,486		30,486			33
34	Rent-Facility & Grounds			375,000	375,000		375,000	(363,251)	11,749			34
35	Rent-Equipment & Vehicles			17,020	17,020		17,020	5,419	22,439			35
36	Other (specify):* STORAGE			765	765		765		765			36
37	TOTAL Ownership			619,007	619,007		619,007	(71,265)	547,742			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,313	289,382	392,695		392,695		392,695			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		103,313	355,082	458,395		458,395		458,395			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,865,537	432,778	2,500,332	4,798,647		4,798,647	(479,028)	4,319,619			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,907)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,086)	2		13
14	Non-Care Related Interest	(54,377)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(22)	21		18
19	Entertainment	(26,553)	20		19
20	Contributions	(6,005)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,044)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(114,085)	27		24
25	Fund Raising, Advertising and Promotional	(22,816)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,222)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(35,598)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (277,715)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(201,313)	PG 6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (201,313)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (479,028)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MAPLE RIDGE CARE CENTRE

ID# 0042366

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (7,138)	6	1
2	VACATION ACCRUAL	(3,316)	1	2
3	VACATION ACCRUAL	(4,282)	3	3
4	VACATION ACCRUAL		4	4
5	VACATION ACCRUAL	(193)	6	5
6	VACATION ACCRUAL	(18,966)	10	6
7	VACATION ACCRUAL	(792)	11	7
8	VACATION ACCRUAL	(911)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(35,598)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(3,316)	0	0	0	0	0	0	0	0	0	0	(3,316)	1
2	Food Purchase	(1,086)	0	0	0	0	0	0	0	0	0	0	(1,086)	2
3	Housekeeping	(4,282)	0	0	0	0	0	0	0	0	0	0	(4,282)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,331)	0	0	0	0	0	0	0	0	0	0	(7,331)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(16,015)	0	0	0	0	0	0	0	0	0	0	(16,015)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(18,966)	7,895	0	0	0	0	0	0	0	0	0	(11,071)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(792)	0	0	0	0	0	0	0	0	0	0	(792)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,758)	7,895	0	0	0	0	0	0	0	0	0	(11,863)	16
	C. General Administration													
17	Administrative	0	(374,934)	0	0	0	0	0	0	0	0	0	(374,934)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,044)	3,922	38,312	0	0	0	0	0	0	0	0	41,190	19
20	Fees, Subscriptions & Promotions	(58,596)	1,134	0	0	0	0	0	0	0	0	0	(57,462)	20
21	Clerical & General Office Expenses	(933)	95,926	0	0	0	0	0	0	0	0	0	94,993	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,295	0	0	0	0	0	0	0	0	0	6,295	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,667	20,451	0	0	0	0	0	0	0	0	24,118	26
27	Other (specify):*	(114,085)	0	0	0	0	0	0	0	0	0	0	(114,085)	27
28	**TOTAL General Administration**	(174,658)	(263,990)	58,763	0	0	0	0	0	0	0	0	(379,885)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(210,431)	(256,095)	58,763	0	0	0	0	0	0	0	0	(407,763)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(12,907)	4,286	166,160	0	0	0	0	0	0	0	0	157,539	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(54,377)	0	183,405	0	0	0	0	0	0	0	0	129,028	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,749	(375,000)	0	0	0	0	0	0	0	0	(363,251)	34
35	Rent-Equipment & Vehicles	0	5,419	0	0	0	0	0	0	0	0	0	5,419	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(67,284)	21,454	(25,435)	0	0	0	0	0	0	0	0	(71,265)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(277,715)	(234,641)	33,328	0	0	0	0	0	0	0	0	(479,028)	45

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
OWNERS		HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE, IL	
				MAPLE RIDGE LLC		
					MORTON GROVE, IL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 7,895	$ 7,895	1
2	V	17	ADMINISTRATIVE	386,995	MR. BELLOWS OWNS 95% OF THIS FACILITY		12,061	(374,934)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		3,922	3,922	3
4	V	20	DUES & SUBSCRIPTIONS				1,134	1,134	4
5	V	21	CLERICAL				95,926	95,926	5
6	V	24	TRAVEL				6,295	6,295	6
7	V	26	INSURANCE				3,667	3,667	7
8	V	30	DEPRECIATION				4,286	4,286	8
9	V	34	RENT				11,749	11,749	9
10	V	35	RENT-EQUIPMENT & VEH.				5,419	5,419	10
11	V								11
12	V								12
13	V								13
14	Total			$ 386,995			$ 152,354	$ * (234,641)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 375,000	MAPLE RIDGE LLC		$	$ (375,000)	15
16	V	19	ACCOUNTING FEES		" "		1,488	1,488	16
17	V	19	LEGAL FEES		" "		1,622	1,622	17
18	V	19	OTHER PROFESSIONAL		" "		35,202	35,202	18
19	V	26	INSURANCE - MORTGAGE		" "		20,451	20,451	19
20	V	30	DEPRECIATION - BLDG/IMPROV		" "		98,242	98,242	20
21	V	30	DEPRECIATION - EQPT				67,918	67,918	21
22	V	32	AMORTIZATION - MTG COST				2,162	2,162	22
23	V	32	INTEREST - MORTGAGE				144,745	144,745	23
24	V	32	INTEREST - OTHER				36,498	36,498	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 375,000			$ 408,328	$ * 33,328	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	0.95	SEE ATTACHED	2	8.26	SALARY	12,061	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,061		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	496,459	9	$ 95,479	$ 95,479	41,050	$ 7,895	1
2	17	ADMINISTRATIVE	PATIENT DAYS	496,459	9	145,864	145,864	41,050	12,061	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	496,459	9	47,431		41,050	3,922	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	496,459	9	13,714		41,050	1,134	4
5	21	CLERICAL	PATIENT DAYS	496,459	9	190,601		41,050	15,761	5
6	21	CLERICAL	DIRECT COST	1	1	80,165	80,165	1	80,165	6
7	24	TRAVEL	PATIENT DAYS	496,459	9	76,130		41,050	6,295	7
8	26	INSURANCE	PATIENT DAYS	496,459	9	44,347		41,050	3,667	8
9	30	DEPRECIATION	PATIENT DAYS	496,459	9	51,835		41,050	4,286	9
10	34	RENT	PATIENT DAYS	496,459	9	142,084		41,050	11,749	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	496,459	9	65,539		41,050	5,419	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 953,189	$ 321,508		$ 152,354	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - LANDMARK PROPERTIES						$	$			$	1
2	AMERICAN NATIONAL BK		X	MORTGAGE	VARIES	11/96	2,980,000	PAID OFF			39,058	2
3	LOAN COST		X	LOAN COST			88,196	72,084			2,162	3
4	GMAC MORTGAGE CO		X	MORTGAGE	$36,865.00	07/2002	3,715,350	3,704,046	07/2037	6.6600	105,687	4
5												5
	Working Capital											
6	AMERICAN NATIONAL BK		X	WORKING CAPITAL	DEMAND	VARIES	500,000		DEMAND	PRIME +	8,049	6
7	RELATED FACILITIES	X		WORKING CAPITAL	DEMAND	DEMAND	783,000	2,456,150	DEMAND	PRIME +	153,452	7
8												8
9	TOTAL Facility Related				$36,865.00		$ 8,066,546	$ 6,232,280			$ 308,408	9
	B. Non-Facility Related*											
10	RELATED FACILITIES	X		WORKING CAPITAL	DEMAND	VARIES	707,873	707,873	DEMAND	VARIES	36,498	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 707,873	$ 707,873			$ 36,498	14
15	TOTALS (line 9+line14)						$ 8,774,419	$ 6,940,153			$ 344,906	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 29,016	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 29,586	2
3. Under or (over) accrual (line 2 minus line 1).		$ 570	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 29,916	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 30,486	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	29,260	8
	1998	29,229	9
	1999	29,063	10
	2000	28,695	11
	2001	29,586	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAPLE RIDGE CARE CENTRE COUNTY LOGAN

FACILITY IDPH LICENSE NUMBER 0042366

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-029-019-00	NURSING HOME	$ 29,586.24	$ 29,586.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 29,586.24	$ 29,586.24

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,774 B. General Construction Type: Exterior MASONRY Frame STEEL/WOOD Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	170,750	1996	$ 148,352	1
2					2
3	TOTALS	170,750		$ 148,352	3

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1996		$ 2,496,225	$ 90,772	27.5	$ 90,772	$	$ 563,542	4
5			1997		15,792	574	27.5	574		3,134	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - MAPLERIDGE LLC										9
10	DINING ROOM REMODELING			1997	7,441	271	27.5	271		1,477	10
11	FENCE			1997	4,300	156	27.5	156		853	11
12	WALLCOVERING/TILE WORK			1997	11,399	415	27.5	415		2,263	12
13	INSTALLATION OF WALLCOVERING			1997	10,590	385	27.5	385		2,102	13
14	FLOOR TILES/INSTALLATION			1997	1,160	42	27.5	42		230	14
15	OUTDOOR SIGN			1997	10,880	396	27.5	396		2,160	15
16	WALLCOVERING/TILE WORK/INSTALLATION			1998	30,545	1,111	27.5	1,111		4,952	16
17	WALLCOVERING/DRYWALL/WINDOW FRAMES			1999	31,471	1,144	27.5	1,144		3,958	17
18	OUTDOOR SIGN			1999	4,190	152	27.5	152		527	18
19	PAVEMENT			1999	6,230	227	27.5	227		783	19
20	REMODELING, OFFICE, ROOF CURB, DOORS			2000	22,801	829	27.5	829		2,038	20
21	WALLCOVERING, PAINTING			2000	3,683	134	27.5	134		329	21
22	PAINT & PREP ALL DOORS, BATHROOMS, KITCHEN,STORE RMS			2001	13,835	503	27.5	503		734	22
23	EDGE VENEER CUNTER TOPS			2001	1,028	37	27.5	37		55	23
24	REMOVE & INSTALL 105 SYSTEM RUBBER ROOFING			2001	9,880	359	27.5	359		524	24
25	REPLACE DAMAGED SOFFIT & FASCIA ON THE OUTSIDE			2001	2,486	90	27.5	90		132	25
26	TEAR OUT AND REBUILD SECTION OF ASPHALT PRKG LOT			2002	4,477	75	27.5	75		75	26
27	EXTEND 2 WALLS TO ROOF DECK & DRY WALL COVER			2002	4,034	67	27.5	67		67	27
28	NURSING STATION - CALL LIGHT SYSTEM			2002	28,723	479	27.5	479		479	28
29	RUN ELECTRICITY OUT TO THE PAVILLION			2002	1,396	24	27.5	24		24	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,722,566	$ 98,242		$ 98,242	$	$ 590,438	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 260,658	$ 31,322	$ 20,600	$ (10,722)	3-15 YRS	$ 90,935	71
72	Current Year Purchases	14,563	2,913	728	(2,185)	3-15 YRS	728	72
73	Fully Depreciated Assets							73
74	RELATED PARTIES	712,760	72,204	72,204			444,154	74
75	TOTALS	$ 987,981	$ 106,439	$ 93,532	$ (12,907)		$ 535,817	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,858,899	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 204,681	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 191,774	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,907)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,126,255	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 13,183 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	$ 295.13	$ 3,837	17
18					18
19					19
20					20
21	TOTAL		$ 295.13	$ 3,837	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[X]
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,953	$	$ 1,953
2	Books and Supplies		280		280
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		524		524
9	TOTALS	$	$ 2,757	$	$ 2,757
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,757			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 98,854	$		$ 98,854	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			68,674			68,674	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			121,374			121,374	4
5	Physician Care		visits			320			320	5
6	Dental Care	39-3	visits			160			160	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				62,745		62,745	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTAL, I.V. THERAPY Other (specify):	39-2					40,568		40,568	13
14	TOTAL			$		$ 289,382	$ 103,313		$ 392,695	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 441,289	$ 560,304	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 9,407)	943,107	943,107	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,108	89,555	6
7	Other Prepaid Expenses	69,483	69,483	7
8	Accounts Receivable (owners or related parties)	1,145,012	464,445	8
9	Other(specify): ESCROW DEPOSIT	18,338	103,878	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,674,337	$ 2,230,772	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		585,600	13
14	Buildings, at Historical Cost		3,318,321	14
15	Leasehold Improvements, at Historical Cost		226,340	15
16	Equipment, at Historical Cost	256,681	1,115,856	16
17	Accumulated Depreciation (book methods)	(183,935)	(1,751,267)	17
18	Deferred Charges	4,933	121,197	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	42,884	1,111,315	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 120,563	$ 4,727,362	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,794,900	$ 6,958,134	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 242,364	$ 260,964	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,911	7,911	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,344	50,344	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,587	6,587	31
32	Accrued Real Estate Taxes(Sch.IX-B)		29,916	32
33	Accrued Interest Payable	17,478	26,900	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	262,466	262,466	36
37	DUE TO IDPA	29,444	29,444	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 616,594	$ 674,532	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,456,150		39
40	Mortgage Payable		5,974,267	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,456,150	$ 5,974,267	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,072,744	$ 6,648,799	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (277,844)	$ 309,335	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,794,900	$ 6,958,134	48

***(See instructions.)**

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (433,365)	1
2	Restatements (describe):		2
3	ROUNDING ADJUSTMENT	(5)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (433,370)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	155,526	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 155,526	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (277,844)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,899,796	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,899,796	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54,377	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,377	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,954,173	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	777,244	31
32	Health Care	1,473,069	32
33	General Administration	1,470,932	33
	B. Capital Expense		
34	Ownership	619,007	34
	C. Ancillary Expense		
35	Special Cost Centers	392,695	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,798,647	40
41	**Income before Income Taxes (line 30 minus line 40)****	155,526	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 155,526	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,102	$ 55,958	$ 26.62	1
2	Assistant Director of Nursing	1,702	1,954	40,798	20.88	2
3	Registered Nurses	1,905	2,078	51,466	24.77	3
4	Licensed Practical Nurses	27,662	29,801	492,193	16.52	4
5	Nurse Aides & Orderlies	63,746	67,200	618,073	9.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,666	10,257	94,405	9.20	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,464	4,674	49,269	10.54	14
15	Cook Helpers/Assistants	13,419	14,107	100,254	7.11	15
16	Dishwashers					16
17	Maintenance Workers	2,727	2,995	43,135	14.40	17
18	Housekeepers	16,575	17,389	145,970	8.39	18
19	Laundry	3,649	3,871	23,904	6.18	19
20	Administrator	2,056	2,286	59,878	26.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,128	5,937	90,234	15.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,651	164,651	$ 1,865,537 *	$ 11.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	211	$ 10,637	1-3	35
36	Medical Director	96	18,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	146	4,717	10-3	38
39	Pharmacist Consultant	96	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,732	11-3	44
45	Social Service Consultant	48	2,732	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	645	$ 40,018		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHELLE EYRSE	ADMIN		$ 59,878
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,878

B. Administrative - Other

Description		Amount
FIRST HEALTH CARE	MANAGEMENT FEES	$ 386,995
TOTAL (agree to Schedule V, line 17, col. 3)		$ 386,995
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		141,693
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 141,693

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,774
Unemployment Compensation Insurance	16,123
FICA Taxes	141,728
Employee Health Insurance	174,212
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	5,858
EMPLOYEE PHYSICAL EXAMS	4,724
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 381,419

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	395
Health Care Worker Background Check	1,061
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	52,591
TRUST/FRANCHISE/CONTRIB/ETC	6,005
LICENSES & PERMITS	1,098
DUES & SUBSCRIPTIONS	9,878
MGMT CO ALLOCATION	1,134
TRUST/FRANCHISE/CONTRIB/ETC	(6,005)
Less: Public Relations Expense	(26,553)
Non-allowable advertising	(22,816)
Yellow page advertising	(3,222)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,566

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	886
RELATED PARTY	6,295
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,181

**See instructions.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/1999	$ 9,372	3	$ 1,562	$ 3,124	$ 3,124	$ 1,562	$	$	$	$	$
2	PAINT/DECORATING	06/2000	1,366	3		228	455	455	228				
3	PAINT/DECORATING	06/2001	3,199	3			533	1,066	1,066	534			
4	PAINT/DECORATING	06/2002	12,265	3				2,044	4,088	4,088	2,045		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 26,202		$ 1,562	$ 3,352	$ 4,112	$ 5,127	$ 5,382	$ 4,622	$ 2,045	$	$

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. HEALTHCARE ASSOC. - $6960**

(3) Did the nursing home make political contributions or payments to a political action organization? _____ If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **577** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: MAPLE RIDGE CARE CENTRE **#0042366** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,637	
	REPAIRS & MAINTENANCE		0	
			0	10,637
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		94	
			0	94
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		0	
	ELECTRICITY		88,848	
	WATER		41,971	
	CABLE TV - LOBBY		1,738	
			0	132,557
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,772	
	PAINTING & DECORATING		12,265	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,768	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		1,175	
	EXTERMINATING SERVICE		5,429	
	FIRE SERVICE		2,899	
	DEFERRED MAINTENANCE		1,675	
			0	
			0	33,983
7	**OTHER**			
	SCAVENGER		11,340	
	SECURITY SERVICE		2,090	13,430
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	18,000	18,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	4,717	
			0	
			0	5,917
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		3,488	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		2,318	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	5,806
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,732	
			0	2,732
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,732	
			0	2,732
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	2,757	2,757

Facility Name & ID Number MAPLE RIDGE CARE CENTRE **#0042366** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	386,995	386,995
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,230	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	127,463	
			0	141,693
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	26,553	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	22,816	
	EMPLOYEE WANT ADS	XIX F	395	
	CONTRIBUTIONS	VI 20 XIX F	1,405	
	DUES & SUBSCRIPTIONS	XIX F	9,878	
	LICENSES & PERMITS	XIX F	1,098	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	3,222	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,600	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,061	71,028
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,326	
	EQUIPMENT REPAIR & MAINTENANCE		1,497	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	22	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,315	
	TELEPHONE		82,758	
	MESSENGER SERVICE		2,260	
			0	90,178

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	141,728	
	UNEMPLOYMENT COMPENSATION	XIX D	16,123	
	WORKERS COMPENSATION INSURANC	XIX D	38,774	
	HOSPITALIZATION INSURANCE	XIX D	174,212	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,858	
	EMPLOYEE PHYSICAL EXAMS	XIX D	4,724	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	381,419
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		11,582	11,582
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	886	
			0	
			0	886
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,163	6,163
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		93,569	93,569
27	**OTHER**			
	BAD DEBTS	VI 24	114,085	
			0	114,085

GRAND TOTAL COLUMN 3 OTHER 1,526,243

MAPLE RIDGE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	156,212	PATIENT MEALS	123150
LESS SALES TAX	(1,086)	ADD EMPLOYEE MEALS	0
NET FOOD	155,126	TOTAL MEALS/YEAR	123150
TOTAL PATIENT CENSUS	41,050	NET FOOD	155126
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	123150
TOTAL PATIENT MEALS	123150	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

MAPLE RIDGE CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										4,836,436	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		1,473,069	381,419	404,818	33,677	338,749	1,089,513	65,700	619,007		1,865,537
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	2,492		2,710			11,818		(17,020)		
	CABLE TV			(1,738)			1,738				
	CONTRACT NURSING										
	INTEREST INCOME							(54,377)			
	NET VENDING COMMISSIONS										
	EMPLOYEE PHYSICAL EXAMS		(4,724)				4,724				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						(386,995)		386,995		
	O2 INCOME/RENT INSURANCE						(81,500)		81,500		
	BAD DEBTS						(114,085)	114,085			
	DISCOUNTS LOST							0			
	ANCILLARIES	392,695							0		
	SETTLEMENT INTEREST										
	RECLASSED SALARIES/COSTS REBILLE	0	0	0	0	0	0	0	0		2,850
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	(63,360)	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		1,868,256	376,695	405,790	33,677	338,749	525,213	62,048	1,070,482	4,680,910	1,868,387
PER FINANCIAL STATEMENTS		1,868,256	376,695	405,790	33,677	338,749	525,213	62,048	1,070,482	155,526	1,868,387
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										155,526	

MAPLE RIDGE CARE CENTRE - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		43,800			43800			0	43920		
CENSUS DAYS		41,050			41736			(686)	42622		
OCCUPANCY %		93.72%			95.29%				97.04%		
SALARIES											
TOTAL General Services	8-1	362,532	8.39%	8.83	343858	8.49%	8.24	18,674	358596	9.44%	8.41
Social Services	12-1	0	0.00%	0.00	4149	0.10%	0.10	(4,149)	0	0.00%	0.00
TOTAL Health Care and Programs	16-1	1,352,893	31.32%	32.96	1312836	32.42%	31.46	40,057	1240140	32.66%	29.10
Clerical & General Office Expenses	21-1	90,234	2.09%	2.20	115331	2.85%	2.76	(25,097)	100662	2.65%	2.36
TOTAL General Administration	28-1	150,112	3.48%	3.66	171083	4.22%	4.10	(20,971)	166918	4.40%	3.92
TOTAL Operation Expense	29-1	1,865,537	43.19%	45.45	1827777	45.14%	43.79	37,760	1765654	46.50%	41.43
ADJUSTED TOTALS											
Food	2-8	155,126	3.59%	3.78	159593	3.94%	3.82	(4,467)	155384	4.09%	3.65
Heat and Other Utilities	5-8	132,557	3.07%	3.23	113550	2.80%	2.72	19,007	120837	3.18%	2.84
Maintenance	6-8	89,121	2.06%	2.17	85216	2.10%	2.04	3,905	77041	2.03%	1.81
TOTAL General Services	8-8	761,229	17.62%	18.54	737363	18.21%	17.67	23,866	744043	19.60%	17.46
Administrative	17-8	71,939	1.67%	1.75	67462	1.67%	1.62	4,477	80278	2.11%	1.88
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	182,883	4.23%	4.46	161717	3.99%	3.87	21,166	167601	4.41%	3.93
Fees, Subscriptions, Promotions	20-8	13,566	0.31%	0.33	17986	0.44%	0.43	(4,420)	10543	0.28%	0.25
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	200	0.01%	0.00
License Fee-Other	Pg21	1,098	0.03%	0.03	312	0.01%	0.01	786	761	0.02%	0.02
Clerical & General Office Expenses	21-8	298,627	6.91%	7.27	314073	7.76%	7.53	(15,446)	280516	7.39%	6.58
Employee Benefits & Payroll Taxes	22-8	381,419	8.83%	9.29	370807	9.16%	8.88	10,612	331766	8.74%	7.78
Payroll Taxes	Pg21	157,851	3.65%	3.85	162422	4.01%	3.89	(4,571)	173368	4.57%	4.07
W/C Insurance	Pg21	38,774	0.90%	0.94	34748	0.86%	0.83	4,026	27323	0.72%	0.64
Health Insurance	Pg21	174,212	4.03%	4.24	133740	3.30%	3.20	40,472	95298	2.51%	2.24
Inservice Training & Education	23-8	11,582	0.27%	0.28	5744	0.14%	0.14	5,838	10560	0.28%	0.25
Travel and Seminar	24-8	7,181	0.17%	0.17	8924	0.22%	0.21	(1,743)	10718	0.28%	0.25
Other Admin. Staff Transportation	25-8	6,163	0.14%	0.15	8065	0.20%	0.19	(1,902)	18927	0.50%	0.44
Insurance-Prop.Liab.Malpractice	26-8	117,687	2.72%	2.87	82793	2.04%	1.98	34,894	54722	1.44%	1.28
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	1,091,047	25.26%	26.58	1037571	25.62%	24.86	53,476	965631	25.43%	22.66
TOTAL Operation Expense	29-8	3,313,482	76.71%	80.72	3211690	79.31%	76.95	101,792	3064631	80.71%	71.90
Real Estate Taxes	33-3	30,486	0.71%	0.74	28839	0.71%	0.69	1,647	27873	0.73%	0.65
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	4,319,619	100.00%	**105.23**	4049454	100.00%	**97.03**	270,165	3796983	100.00%	**89.09**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1575669.8	36.48%	**38.38**	1508594.7	37.25%	**36.15**	67,075	1476652	38.89%	**34.65**

MAPLE RIDGE CARE CENTRE - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 5127 from Page 22 and -12265 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-183405
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-170446
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.